

VISTA CARE REMINDER SHEET

Please read carefully and initial beside each item

- _____ I have been determined eligible (income and otherwise) to receive childcare benefits through VISTA Care. I understand that my state determines income eligibility requirements.
- _____ I understand that VISTA Care can only pay **up to** the local market rate for child care fees and that this rate cannot exceed \$300.00 per member, per month.
- _____ I am a full-time VISTA member.
- _____ I understand that I must select a **legal** caregiver, that my state determines who is considered a legal caregiver and that VISTA Care cannot reimburse my caregiver unless all state requirements are met.
- _____ I understand that I must give VISTA Care a minimum of two (2) weeks notice when changing caregivers by submitting a **Change of Caregiver Form** and a new **Caregiver Information and Registration form**.
- _____ I understand that I must notify my program officer immediately if plan to resign from VISTA. Final payments to my caregiver cannot be made until I complete a **Termination of Child Care Benefits Form** with my program director **and** submit final coupons (must be correct and complete).
- _____ I understand that I am **not eligible** for childcare through VISTA Care if I am already receiving a childcare subsidy from another source, nor will VISTA Care cover any co-pay on existing childcare subsidies.
- _____ I understand that VISTA Care will not reimburse more than one caregiver for the same period of time, for the same child and will only reimburse a maximum of two caregivers at a time.
- _____ I understand that my caregiver must meet the minimum age requirement set by my state (18 yrs. Old in most states).
- _____ I understand that if I use a back-up caregiver, VISTA Care must reimburse my primary caregiver **before** reimbursing my back-up caregiver and that the total monthly payments on my behalf must not exceed \$300.00.
- _____ I understand that VISTA Care will not reimburse me for childcare and that all reimbursements are made directly to the caregiver.

I have read all of the above and understand its content. I also understand that non-compliance with any of the above and/or falsification of information on any VISTA®CARE documents will result in termination of my childcare benefits and that in such a case I may be required to re-pay any monies paid on my behalf.

Member's Name (please print)

Member's Signature

____/____/____
Date

This form must accompany your childcare application and other related forms forwarded to your State Program Officer.